

## Medicare Advantage Plan Election Form Please fill in all information requested. Be sure to read the back of this form.

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## STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage contracting primary care physician (PCP) will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible).

I understand that I can be a member of only one Medicare Advantage coordinated care plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage coordinated care plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including—but not limited to—physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected prior to either permanently moving out of the service area or leaving the service area for more than twelve (12) months, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective with my date of retirement or January 1, if enrolling during the Public Employees Benefits Board (PEBB) annual open enrollment period. I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

**Note:** Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Washington State law may require disclosure of any information you submit as a public record.

The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.